STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Extended Health Resurvey and Complaint investigation #KS00091622.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1	F 156		

including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 2	F 156		

written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 48 residents. Based on observation, record review, and interview, the facility failed to post contact information for the state's complaint hotline. The facility further failed to inform residents of their right to file a grievance with the State agencies.

10/29/2015 2:28 PM resident council member resident #40, stated the facility did have a poster with the state complaint hotline on a bulletin board in the activities room. The facility painted that wall about 3 months ago and did not put the poster back up.

Observation of the facility lacked posting of the state complaint hotline on any of the bulletin boards in the facility.

On 10/29/15 at 2:43 P.M. activities staff A stated the state's complaint hotline number was not posted outside of his/her office or or any other location in the facility.

On 11/02/15 at 2:41 P.M. administrative staff A stated he/she expected to have the state's complaint hotline number posted at all times and it was his/her job to make sure it was posted at all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 3 times. He/she did not know the wall was painted and the poster was removed. The facility had been doing environmental upgrades and painting. The undated facility's Resident's Rights under State Law policy noted residents had the right to voice grievances and recommend changes in policy and services to the staff of outside representative(s) of their choice, without restraint, interference, coercion, discrimination, or reprisal. Grievances may be voiced to the facility by utilizing the procedures outlined herein or to any of the following agencies: the State Advocacy & Protective Services, the State Department of Health & Environment, the states long-term care Ombudsman, and SRS. The undated facility's Resident's Rights Under Federal Law policy noted the residents have the right to receive information from agencies acting as client advocates and be afforded the opportunity to contact the agencies. The residents had the right to immediate access to the agency responsible for the protection of and advocacy system for mentally ill or developmentally disable individuals. The facility failed to prominently post the contact information for the State agencies.	F 156		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F	F 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 257	Continued From page 4	F 257		

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 48 residents sample included 13 residents. Based on observation, record review, and interview, the facility failed to maintain comfortable temperatures in 3 resident rooms on 2 of 3 halls, and in the activities room for 2 of 5 days of the survey.

Findings included:

- On 10/27/15 at 10:47 A.M. observation revealed resident #32 sat in his/her room wearing a heavy coat. Record of the ambient room temperature revealed a reading of 70.7 degrees Fahrenheit (F). The resident stated he/she was cold in his/her room.

On 10/27/15 at 1:42 P.M. interview with resident #9 in room stated it was very cold in his/her room in the nights and in the mornings. The residents had to talk with the maintenance staff to adjust the thermostat.

On 10/29/15 at 7:20 A.M. observation revealed resident #15 laid in bed with covers over his/her head stated it was very cold in his/her room, it was too cold to get out of the covers. The ambient temperature in room was 64.2 degrees F.

On 10/29/15 at 7:20 A.M. observation of ambient room temperature in room was 64.5 degrees F.

On 10/29/15 at 7:27 A.M. observation of the ambient room temperature in the common activity room was 67.2 degrees F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 257	Continued From page 5	F 257		

On 10/29/15 at 11:41 A.M. observation of the ambient room temperature in room was 64.5 degrees F. An unidentified resident laid under the covers with his/her head under the covers. He/she stated it was cold in his/her room and did not want to come out of the blankets.

On 10/29/15 at 8:04 A.M. housekeeping staff V stated there were days that the building was always cold.

On 10/29/15 at 11:07 A.M. activities staff Z stated the activities room had a heater for that room with a separate thermostat that controlled the heat in the activities room and the dining room. He/she had only seen one resident put a blanket around his/her shoulders. There was not a certain temperature to warrant turning on the heater.

On 10/29/15 at 12:04 P.M. maintenance staff U stated he/she turned the heat on in the whole building on 10/29/15 at approximately 9:30 A.M.. He/she had to wait to change the air filters before he/she could turn on the heaters. One of the aides brought the cold temperatures in the building to his/her attention. There were resident ' s room temperatures of 65 degrees F. The thermostat was currently set at 75 degrees F and the residents ' rooms on the north hall were 70 degrees F. He/she stated the facility did not keep logs on ambient room temperatures. He/she was not aware of the federal regulation, state regulation or the facility ' s policy.

On 10/29/15 at 2:06 P.M. administrative staff A stated the regulation for ambient room temperatures in resident ' room was 71-81 degrees F, and made sure the room were within that range. He had observed some of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 257	Continued From page 6 residents in gloves. On 11/2/15 at 12:26 P.M. administrative nursing staff D stated he/she expected the ambient room temperatures to be within the regulation temperature. On 11/2/15 at 2:02 P.M. direct care staff N stated he/she would get a resident a blanket or sweater if they complained of being cold. The resident's room did not have individual thermostats and would tell the maintenance staff if a resident complained of being cold. The facility's Air Temperature Readings policy dated April 2005 noted routine checks of ambient air temperature were not required. The staff were to investigate air temperature complaints. The acceptable range for air temperatures was 71 to 81 degrees F. Staff recorded air temperatures by location on the Temperature Log. The facility failed to maintain comfortable room temperatures for the residents who reside in the building.	F 257		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 7 Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: - Resident #30 ' s Annual Minimum Data Set (MDS) dated 2/27/15 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. Review of the Care Area Assessment (CAA) for cognition, nutrition, and dental dated 4/3/15 were developed 36 days after the MDS assessment.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 8	F 272		

Review of the Resident Assessment Instrument (RAI) User ' s Manual 3.0 Version 1.13 stated the RAI must be completed within 14 days of assessment. As an integral part CAAs must be completed and documented within the same time frame

On 11/02/2015 at 12:56 P.M. administrative nursing staff D, stated he/she was on leave from 2/20/15 to the end of May 2015, at that time he/ she was the MDS coordinator and was responsible for the completion of the CAAs.

Review of the facility policy for Resident Assessment Instrument (RAI) process dated October 2010 revealed the facility conducts a comprehensive assessment (MDS) including Care Area Assessments to identify the resident ' s needs within 14 days.

The facility failed to complete the CAAs timely for this resident ' s assessment

- Resident # 17 ' s Annual Minimum Data Set (MDS) dated 2/27/15 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition.

Review of the Care Area Assessment (CAA) for cognition and activities of daily living dated 4/17/15 were developed 49 days after the MDS assessment.

Review of the Resident Assessment Instrument (RAI) Users Manual 3.0 Version 1.13 the RAI must be completed within 14 days of admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 9 As an integral part of the RAI, CAAs must be completed and documented within the same time frame On 11/02/2015 at 12:56 P.M. administrative nursing staff D , stated he/she was on leave from 2/20/15 to the end of May 2015, at that time he/ she was the MDS coordinator, and was responsible for the completion of the CAAs. Review of the facility policy for Resident Assessment Instrument (RAI) process dated October 2010 revealed the facility conducts a comprehensive assessment (MDS) including Care Area Assessments to identify the resident ' s needs within 14 days. The facility failed to complete the CAAs timely for this resident ' s assessment - Resident # 36 ' s Annual Minimum Data Set (MDS) dated 2/14/15 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. Review of the Care Area Assessment (CAA) for cognition and psychotropic medications dated 3/26/15 were developed 40 days after the MDS assessment. Review of the Resident Assessment Instrument (RAI) User ' s Manual 3.0 Version 1.13 the RAI must be completed within 14 days of admission. As an integral part of the RAI, CAAs must be completed and documented within the same time frame	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 10 On 11/02/2015 at 12:56 P.M. administrative nursing staff D , stated he/she was on leave from 2/20/15 to the end of May 2015, at that time he/ she was the MDS coordinator, and was responsible for the completion of the CAAs. Review of the facility policy for Resident Assessment Instrument (RAI) process dated October 2010 revealed the facility conducts a comprehensive assessment (MDS) including Care Area Assessments to identify the resident ' s needs within 14 days. The facility failed to complete the CAA timely for this resident ' s assessment The facility reported a census of 48 residents with 13 residents in the sample. Based on observation, interview, and record review, the facility failed to complete a comprehensive diet assessment for 1 resident (#25), and failed to complete a comprehensive assessment of triggered Care Area Assessments (CAA) for 5 residents reviewed. (#9, #15, #30, #17, and #36) Findings Included: - Review of resident #25's admission MDS (Minimum Data Set) dated 6/5/15 noted the resident required staff supervision of setup only with eating, was on a prescribed weight-loss program, and received a mechanically altered diet.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 11	F 272		

The Care Area Assessment (CAA) for nutritional status dated 6/5/15 noted he/she had a significant weight loss while in the community due to poor self-care and his/her weight had continued to be an issue. He/she received supplements, weight loss complicated the healing of his/her pressure ulcers. Interventions were put into place to prevent further weight loss and to promote appropriate weight gain.

The physician's order dated 5/29/15 for a regular diet, mechanical soft texture, regular consistency.

On 10/28/15 at 12:31 P.M. the resident sat in his/her wheelchair at the dining room table, fed him/herself roast beef, cooked carrots, and mashed potatoes. The resident ate 50% of the meal.

On 10/29 at 11:28 A.M. resident #25 stated staff gave him/her shakes several times a day. He/she did not like the staff giving him/her so much food because he/she did not want to get fat.

On 11/02/15 at 4:54 P.M. administrative nursing staff E stated the facility followed the Resident Assessment Instrument (RAI) manual. He/she stated resident #25 had not been on a weight loss diet.

On 11/02/15 at 12:41 P.M. administrative nursing staff D stated resident #25 had never been on a weight loss program.

On 10/28/15 consultant staff HH stated the resident was very emaciated when he/she came to the facility.

The facility's Resident Assessment Instrument

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 12	F 272		

(RAI) Process policy revised 10/2010 noted the MDS provided a core set of screening, clinical, and functional status elements that formed the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid and included review of the resident ' s medical records. The MDS was reviewed for accuracy by the interdisciplinary team.

The facility failed to correctly complete the admission MDS for this resident.

- Resident #15's Annual Minimum Data Set (MDS) dated 2/14/15 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition.

Review of the Care Area Assessment (CAA) for psychotropic medication, behaviors, and mood dated 3/30/15 were developed 44 days after the MDS assessment.

On 11/2/15 at 10:24 A.M. the resident visited with other residents in the common living room.

Review of the Resident Assessment Instrument (RAI) User's Manual 3.0 Version 1.13 stated the RAI must be completed within 14 days of assessment. As an integral part CAAs must be completed and documented within the same time frame

On 11/02/2015 at 12:56 P.M. administrative nursing staff D, stated he/she was on leave from 2/20/15 to the end of May 2015, at that time he/ she was the MDS coordinator and was responsible for the completion of the CAAs. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 13	F 272		

staff were expected to complete the CAAs within 7 days from the Assessment Reference Date (ARD) date.

Review of the facility policy for Resident Assessment Instrument (RAI) process dated October 2010 revealed the facility conducts a comprehensive assessment (MDS) including Care Area Assessments to identify the resident's needs within 14 days.

The facility failed to complete the CAAs timely for this resident's assessment.

- Resident #9's significant change Minimum Data Set (MDS) dated 3/25/15 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition.

Review of the Care Area Assessment (CAA) for Activities of Daily Living (ADL) dated 4/6/15 were developed 12 days after the MDS assessment and the CAA for psychotropic medication dated 4/9/15 were developed 15 days after the MDS assessment.

On 10/29/15 at 7:47 A.M. the resident ate morning meal the dining room table.

Review of the Resident Assessment Instrument (RAI) User's Manual 3.0 Version 1.13 stated the RAI must be completed within 14 days of assessment. As an integral part CAAs must be completed and documented within the same time frame

On 11/02/15 at 4:57 P.M. administrative nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 14 staff E stated the MDS process followed the RAI manual and the resident's CAAs were not completed timely. On 11/02/15 at 12:39 P.M. administrative nursing staff D stated the staff were expected to complete the CAA according to the RAI manual. Review of the facility policy for Resident Assessment Instrument (RAI) process dated October 2010 revealed the facility conducts a comprehensive assessment (MDS) including Care Area Assessments to identify the resident's needs within 14 days. The facility failed to complete the CAAs timely for this resident's assessment.	F 272		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 48 residents with 13 residents sampled. One resident identified as an elopement risk. Based on interview and record review of a closed record, the facility failed to provide adequate supervision for 1 resident (#35), who staff identified at increased risk for elopement earlier in the shift,	F 323	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15	F 323		

left the facility unattended and without staff knowledge. The resident ambulated approximately one city block without his/her walker and fell sustaining abrasions to his/her hands and knees. This failure placed the resident in immediate jeopardy.
Findings included:
- Resident #35 ' s clinical record documented diagnoses of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest.) dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and abnormal gait (a deviation from normal walking).
Review of the Quarterly Minimum Data Set (MDS) 7/2/15 recorded the resident with a BIMS (Brief Interview for Mental Status) of 14, indicating intact cognition. The resident required limited assistance of 1 staff member for dressing and used a walker for mobility.

Review of the Care Area Assessment (CAA) dated 4/10/15 for cognition recorded the resident ' s cognition varied. He/she knows the day, date and day of the week at times although not always at the same time. His/ her short and long term memory were compromised due to his/her thinking and his/her mental illness, had poor insight and judgment. He/she had issues with making decisions based upon delusional beliefs. His/her cognition had worsened over the past few months.

The CAA for falls dated 4/10/15 recorded a potential for falls due to weakness/poor stamina, psychotropic medication use, poorly controlled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16 diabetes and mental illness. The CAA for Behaviors dated 4/10/15 recorded the resident wheeled around the facility reporting that he/she doesn't have any particular place to go, when asked. Doubtful if truly "wandering", does have issues with attempting to leave the facility for various reasons. Review of the fall risk assessment dated 8/11/15 recorded a score of 17 indicating the resident was a high risk for falls. Review of the fall risk assessment dated 10/13/15 recorded a score of 18 indicating the resident remained a high risk for falls. Review of the elopement assessment dated 8/11/15 recorded a score of 16 indicating the resident was at risk for elopement. Review of the elopement assessment dated 10/13/15 recorded a score of 15 indicating the resident remained at risk for elopement. The plan of care dated 6/15/15 recorded the resident was a fall risk due to psychotropic medications, had altered thought process related to mental illness, he/she had attempted to leave the facility when he/she was experiencing an increase in psychosis. Staff to monitor the residents whereabouts when he/she was noted to have an increase in psychosis, has poor insight related to his/her mental illness, redirect as needed from unsafe behaviors, was usually redirectable, if not this was unusual and report to the charge nurse. Encourage to use walker when he/she was	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17	F 323		

feeling weak or more tired than usual, encourage to take a break if he/she becomes short of breath while walking. The resident wore glasses. Ensure they are clean (he/she usually cleans them but when not doing well needs assistance) and that he/she is wearing them. This can help prevent falls. The resident had reported having command hallucinations. These can tell him/her to leave, hurt self, hit, or other unsafe things. Provide safety measures as needed such as monitoring whereabouts if being told by voices to leave.

A nurse ' s note dated 9/13/15 and timed 10:48 P.M. recorded as licensed staff H reported for work at the facility at 2 P.M., the resident was at the front door of the building. He/she had his/her walker and was asked to come in. The resident went to the television room with peers. After shift report, the resident ' s mood was discussed with staff, and to be aware of the potential to elope.

Review of the facility investigations documented on 9/13/15 at approximately 7:20 P.M. direct care staff P received a phone call that a resident of the facility was down the street. Facility staff brought the resident back to the facility at approximately 7:27 P.M. Staff P had cued the resident to use the toilet immediately prior to the elopement and confirmed the resident was in his/her room. Assessment of the resident upon return to the facility revealed abrasions on both palms and knees and a bruise to right shoulder. Staff estimated the resident was away from the facility unsupervised 5 to 7 minutes.
The resident left via the south door of the facility and got approximately 2 houses away from the facility and fell. The resident did not take his/her walker with him/her when exiting the facility. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18	F 323		

doors were alarmed and a camera was used to monitor the door with a monitor screen at the nurses ' station. Staff were to keep vigilance on the screen. Staff heard the alarm sound, but did not go to the door and look to observe if anyone went out of the door then staff reset the alarm. Review of the facility investigation submitted to the state agency included an interview with administrative staff B and licensed nurse H dated and signed on 9/18/15 recorded on 9/13/15 at 7:20 P.M. licensed nurse H was charting at the nurses desk, he/she heard the alarm go off, but did not see anyone on the camera, did not go to the door to check because he/she did not see anyone outside. The facility investigation further documented staff H looked at the monitors and there was no one there and silenced the alarm.

Review of the weather source for 9/13/15 listed the temperature at 7:53 P.M. at 75 degrees farenheight, visibility at 10 miles, wind gust speed of 19.6 miles per hour (MPH) and clear. The sun set at 7:34 P.M. There was no speed limit posted on the street the resident was found on. The street the resident was found on dead end approximately 2 blocks north of the nursing home. The area where the resident fell had uneven pavement, with grates and a sewer cover in the street. The mail box for the residence near this area protrudes to the curb. The Resident left through the South door, turned onto the street in front of the facility. The street had a hole in the pavement approximately 1 foot by 1 foot. There was no side walk on the west side of the street, so the resident would have walked on the grass or in the street. On the East side of the street there was a mental health complex and a side walk. The area was residential and business. Observation on days of the survey from 7:00 A.M. to 5:30 P.M. the street was busy with cars,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19	F 323		

trucks, and service vehicles traveling at the estimated speed of 25-30 MPH.
Review of the facility policy for Resident Elopement dated August 2012 listed the facility strived to provide a safe environment and preventive measures for elopement. Personnel must report and investigate all reports of missing residents. If an employee hears a door alarm he or she should: immediately go to the site of the alarm, if a resident was observed attempting to elope, follow the steps outlined in attempted elopement. If no resident was found to exit the facility the employee should exit the facility, walk around the building, and ensure that a resident had not already exited the facility.
The facility policy for Door Monitor Policy not dated listed all outside doors that have resident access are equipped with door monitors to alert staff to people entering and leaving the facility. The monitors are equipped to sound a loud signal at the nurses ' station. The alarm has to be reactivated at the control switch at the nurses ' station. It was the shift supervisor ' s responsibility to check the door monitors at the beginning of each shift and to document in the Door Monitor Log Book that they are in working order. When a door monitor was sounded all staff were to be alert as to who entered or left the building.
On 11/2/15 2:23 P.M. licensed nursing staff G stated the resident was an elopement risk towards the end of his/her stay, he/she had a decline in cares then the voices got worse telling him/her to leave, the medication did not work as well. The voices were constant, he/she could be very combative, needed cues with daily living skills, the invisible people would guide her.

If the door alarm sounds, staff check the monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20	F 323		

to see what alarm it is and then get up to go look to see, the camera might not catch it Nursing monitors it continuously so if I were to leave, the medication aide would watch the monitor or position the cart so the doors could be seen.

On 11/2/15 at 3:27 P.M. direct care staff Q stated the resident was an elopement risk if he/she were at the door staff need to try to distract the resident to something else, take the resident to the patio, have him/her talk with other residents. When the door alarm goes off need to look at the door, if a resident is leaving go after them and need to physically go to the door and look. The camera was monitored by the nurse, and if he/she has to leave an aide will monitor the camera. The camera was always monitored. If a resident walks out of the building and is not supposed to be out, you go out after them and try to redirect them back into the building, stay with them at all times till you can get them back into the building.

On 11/2/15 at 3:31P.M. direct care staff M stated the resident was monitored and not to leave on his/her own. He/she was difficult to redirect at times. When a door alarm goes off, check the door and physically go to the door and look.

On 11/4/15 at 2:40 P.M. licensed staff H stated he/she heard the alarm sound but all door alarms sound the same and people are to go out the front door. She observed the monitor at the nurses station and did not observe anyone leaving on the monitor, asked a staff member who went out the door. The staff named a resident who had privileges to leave the building had gone out the door. He/she received a telephone call the resident was down the street.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21	F 323		

The licensed staff is not to leave the building so he/she asked two direct care staff to go outside to pick up the resident. The direct care staff brought Resident #35 into the building and the licensed staff completed an assessment noting scrapes on the meaty part of the hand. And some superficial scrapes on the knees that probably came from the gravel.

On 11/4/15 at 2:45 direct care staff R stated he/she thought that a relative of the resident who lived in the area called the facility to report that Resident #35 was on the ground maybe a block and a half from the facility. He/she and another direct care staff went outside and asked the resident if he/she was okay and asked if he/she could move his/her legs and if he/she was hurt. The direct care staff noted scrapes on the Resident ' s hands. The two direct care staff put the resident in a van and returned the Resident to the facility. The Resident walked into the facility.

The facility failed to provide a secure environment for this mentally impaired , ambulatory resident who exited the facility without staff awareness. A community member found the resident after he/she fell away from the facility and sustained abrasions to his/her hands and knees and bruising to the right shoulder. This deficient practice placed the resident in immediate jeopardy.
The facility abated the immediate jeopardy on 9/15/15 when all staff attended an in service on resident elopement, door monitoring policies and responsibilities, and there was a change in the audible alarm for the South exit door to a different tone to distinguish the alarm sound for the South door.
This deficient practice remains at the scope and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22 severity of a " D " .	F 323		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 48 residents. Based on interview and record review the facility failed to provide 8 hour Registered Nurse (RN) coverage to meet the resident's needs for nursing care in a manner that promotes each resident's physical, mental and psychosocial well-being, enhancing their quality of life. Findings included: - Review of the facilities schedule from October 1, 2015 to October 31, 2015 revealed the facility did not have RN coverage for 7 of the 31 days of the month, (1,21,22,23,26,27,and 28). On 10/27/15 at 1:35 P.M. Administrative staff A stated he/she realized the facility had a deficient	F 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 354	Continued From page 23 practice. On 11/2/15 at 12:31 P.M .administrative nursing staff D stated there were a few days in October where there was not a registered nurse on duty in the facility. The facility failed to provide 8 hours of continuous RN coverage to meet the resident's needs.	F 354		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 24	F 356		

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 48 residents. Based on observation, record review, and interview the facility failed to complete and retain daily nurse staffing information, and post in a prominent place for 2 of 5 days onsite of the survey.

Findings included:

On 11/3/15 the posting on display in the hall for daily nurse staffing information (Report of Nursing Staff Directly Responsible For Resident Care) for full time equivalencies (FTE) was dated 11/1/15 and lacked a resident census, nursing staff hours for the Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified Nurse Aide (CNA), and Certified Medication Aides (CMA) on the 6:00 A.M. to 2:00 P.M. shift, and on the 2:00 P.M. to 10:00 P.M. shifts. The form noted "daily posting of this information is required for nursing homes participating in Medicare and Medicaid and must be maintained on file for a minimum of 18 months".

Review of the postings from 8/28/15 through 11/1/15 lacked documentation on 8/28/15 for RN coverage on all 3 shifts.

The form dated 8/29/15 lacked a census, day and evening shifts hours for all nursing staff.

The form dated 8/30/15 lacked day and evening

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 25	F 356		

shift hours for nursing staff.

The forms dated 9/6/15, 10/2, 3, 4, 11, 16, 25/15, and 11/1/15 lacked census, day and evening nursing hours.

The facility lacked daily nurse staffing information forms as follows:
April 2015 lacked 18 days out of 30 days
May 2015 lacked 10 days out of 31days
June 2015 lacked 5 days out of 30 days
July 2015 lacked 12 days out of 31 days
August 2015 lacked 14 days out of 31 days
September 2015 lacked 10 out of 30 days
October 2015 lacked 4 out of 31 days.

On 11/03/15 at 8:57 A.M. administrative consultant staff B stated the Report of Nursing Staff Directly Responsible for Resident Care forms should be filled out completely, include the date, the resident census, RN hours, LPN hours, CNA hours, and CMA hours on each shift. He/she acknowledged the forms were not completed. He/she stated they were still looking for the past 18 months of FTE forms.

On 11/03/15 at 9:16 A.M. licensed staff G stated the Director of Nursing was responsible for filling out the FTE sheet.

On 11/03/15 at 12:09 P.M. administrative staff A stated the night shift nurse filled out the FTE. There was not a current and complete posting since 11/1/15.

On 11/03/15 at 12:19 P.M. administrative nursing staff D stated the FTE were filled out for the coming day by the night shift nurse and each shifts charge nurse was responsible for updating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 26 the form. The forms were to be posted daily and kept for 18 months. On 11/3/15 at 1:25 P.M. administrative staff D stated the facility used the form, Report of Nursing Staff Directly Responsible for Resident Care dated 11/3/15, as the facility's policy. The form noted daily posting of this formation (date, census, total number of hours worked each shift for RN, LPN, CNA, and CMA) was required for nursing homes participating in Medicare and Medicaid and must be maintained on file for a minimum of 18 months. The staff were expected to fill the form out completely, post on the bulletin board, and update as needed. The facility failed to post current FTE forms and maintain the records for a minimum of 18 months.	F 356		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 27 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility identified a census of 48 residents. Based on observation, interview, and record review, the facility failed to utilize precautions to minimize transmission of infection on 2 of 3 halls. Findings included: - Observation on 10/29/15 at 3:38 P.M. licensed staff H donned gloves then entered a resident's room, wiped the resident's finger with an alcohol wipe, punched the resident's skin with a single use lancet and obtained blood sample. He/she then went into the hall to the medication cart, touched the drawer handles, and drew insulin as ordered into a syringe. He/she went back into the resident's room and injected the insulin into the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 28	F 441		

resident's right arm. Licensed staff H did not change, or remove gloves during the observation. On 10/29/15 at 3:47 P.M. licensed staff H, stated he/she used gloves to protect him/herself from the resident's blood and protect the resident from germs to reduce the spread of infections. He/she should have changed gloves between getting the resident's blood sample and drawing the insulin.

On 11/02/15 at 12:30 P.M. administrative nursing staff D stated staff were expected to remove gloves before leaving a resident's room, and wash their hands. Licensed staff H should have removed gloves before leaving the resident's room with gloves on, drawing up insulin, and giving an injection.

The facility's Contact Precautions policy dated 2012 noted staff were to complete hand hygiene prior to donning gloves. Gloves should be removed after contact with infective material, and removed before leaving the resident's room with hand hygiene performed immediately.

The facility failed to remove gloves to prevent the spread of infection.
- Observation on 10/29/15 at 11:29 A.M. housekeeping staff V donned gloves, entered a resident's room, sprayed Airex 75 antibacterial heavy duty cleaner on flat surface of television stand then proceeded to the bathroom and sprayed the toilet with the same product. He/she then used a cloth to wipe the inside of the toilet bowl down to the water line, moved to the outside of the toilet bowl, then proceeded to wipe down the toilet rim and seat. He/she did not remove gloves before returning to the cleaning cart to get the broom, then returned to the residents bathroom. At 11:35 A.M. he/she sprayed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 29 dresser and wiped the dresser dry. The cleaning product's label read surface was to stay wet for 3 minutes to kill germs. On 10/29/15 at 11:36 A.M. licensed staff V stated the Airex 75 cleaning product had a 15 to 20 minute kill time. He/she stated he/she usually changed gloves after cleaning the toilet and before leaving a resident's room. On 10/29/15 at 1:42 P.M. housekeeping staff T stated staff were expected to spray surfaces with Airex 75, let stay wet for 3 minutes, then wipe them down. Staff were also expected to clean the toilet last, not wipe the inside of the toilet bowl then wipe the outside, rim, and seat with the same cloth. Staff were expected to remove gloves after cleaning the toilet and before leaving the residents room. The facility's daily patient room cleaning policy dated 7/25/14 noted infection control was the goal of an effective room cleaning technique. It listed Quat (a name brand product) disinfectant was to be used in the residents' room. The facility's Bathroom Cleaning policy revised June 2007 noted staff were to put on gloves, spray the fixture, begin at the top and work downward, the entire fixture must remain wet with the solution for at least three minutes for the disinfectant to work. Staff were to clean the toilet bowl last after all other fixtures had been cleaned, and used a bowl brush to clean the bowl, especially under the rim. The facility failed to appropriately change gloves, clean and disinfect residents' room to prevent the spread of infection.	F 441		
F 497 SS=C	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	F 497		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 497	Continued From page 30	F 497		

The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 48 residents and 12 nurse aides. Based on record review and interview, the facility failed to perform nurse aide performance reviews.

Findings included:

- Record review revealed performance reviews for nurse aides were not completed at least every 12 months.

Review of in-services revealed on 8/08/14 staff had an in-service for Anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). On 8/19/14 staff was in-serviced on Fire Safety. On 9/19/14 staff was in-serviced on Emergency ' s for the Patio. On 9/18/14 staff was in-serviced on the Alarm System. On 9/5/14 staff was in-serviced on the Concerns Process and Ambassador Program, no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175547	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 497	Continued From page 31	F 497		

staff signatures were provided for this in-service. On 10/3/14 staff was in-serviced on Pain. On 11/7/14 staff was in-serviced on Communication. On 12/12/14 staff was in-serviced on Managing Behaviors. On 1/8/15 staff was in-serviced on Abuse, Neglect, and Exploitation. On 3/29/15 staff was in-serviced on Disaster Preparedness. On 9/22/15 staff was in-serviced on Dignity.

A policy was not provided by the facility.

An interview on 11/3/15 at 12:43 P.M. with consultant staff B stated the facility did not provide performance reviews and that was one of their programs to correct.

An interview on 11/3/15 at 12:43 P.M. with administrative staff A stated the facility did not provide performance reviews.

The facility failed to perform nurse aide performance reviews.